

and their main function is to give impartial testimony without any thought of bias for or against a plaintiff or defendant. While this process has not spread very wide to date, it is being carefully observed in many other areas. If it produces the results hoped for, the bickering between expert witnesses in highly contested cases may be eliminated; in fact, many cases may be settled before trial if the impartial medical testimony will not support the legal claims made.

The newest move in California comes as a follow-up of these earlier evidences of collaboration between the two professions. The maintenance of panels of experts for the use of plaintiffs' attorneys in professional liability cases should go a long way toward dispelling the impression which has been voiced by some lawyers and judges that a "conspiracy of silence" exists in the medical profession when a medical malpractice case comes to court. Where panels of medical experts are established to work under the guidance of both the medical and the bar associations, there would be little to sustain this sort of reasoning. The program has been agreed upon by both parties under a set of

rules which will protect all parties against abuses and still make expert testimony available to the plaintiff.

Where large county medical societies are involved, it is expected that the county society will supervise the program through its own staff. In smaller counties, area panels will be developed to work with the cooperation of the district councilor of the California Medical Association. In either event, the medical societies will be advised on all cases and adequate administrative controls will be maintained. [Details are given in the article appearing on page 173 of this issue.]

While only a limited experience has been had in this program to date, it appears obvious that the plan will be put into effect statewide at the earliest possible date and that the medical and legal professions can take another step forward on the path to mutual respect and understanding. But above all, the public will be presented a service which could not be purchased for money but can be extended with good will by the two large professions involved. This is at once good citizenship and good public relations at its very best.

Editorial Comment . . .

Why a Tumor Registry?

THE QUESTION is often asked, "Why should a hospital have a tumor registry?" The administrator questions the cost and asks how such a charge can be justified in terms of service to all the patients cared for in the hospital. The staff member is concerned in what he receives in return for the time spent in obtaining follow-up information since the family physician, to whom the patient is returned for further care, resents the "specialist" periodically asking for information relative to the condition of the patient.

One answer might be that, cancer being a multiplicity of diseases, every method that may provide any information should be developed. There are those who state that the collection of such data for statistical analysis is time consuming and futile, that statistics never cured a case, that all the patients die sooner or later in spite of treatment and perhaps because of treatment. Others, the optimistic ones, say that cancer can be cured in 85 per cent of cases if treated early enough. Between these two groups

are the careful scientific members of the profession who are interested in the results of their therapy not only at the time of discharge of the patient from the hospital but in the years that the patient lives. It is for this group that a cancer registry becomes a valuable tool in treatment and in teaching.

Few persons are endowed with "total recall" memory, and physicians are not especially favored. They, like others, are likely to remember their successes and forget their failures and particularly the details of the cases with the passage of time. Hence the need of accurate recording of the facts as they develop. Such a clinical record becomes quite bulky, and to review all such records for information as to age, sex, site, type, diagnosis and therapy (or reason for no therapy) is time-consuming.

A tumor registry is designed to expedite and make attractive such reviews. Pertinent information is abstracted and filed on all patients with cancer seen in the hospital departments. For the convenience of the specialists the abstracts may be filed according to site of lesion. The follow-up informa-

tion is kept with the abstract and thus a running inventory is maintained. A yearly audit is easily prepared and the staff made aware of the cancer program of the hospital.

The obligation of sharing the knowledge gained through experience is traditional with the medical profession. The means of sharing such knowledge is the presentation of data before medical societies or specialist groups and by writing for the professional journals. The tumor registry provides the basic material for such writings. True, it will be necessary in certain cases to review some clinical records individually for specific details not recorded in the abstracts, but the identification of special cases has been made easier. Since the end results are *sine qua non* evaluating any information, complete follow-up data is essential.

Nothing has been said of the standardization of report forms and of the terms used. So long as the hospital is operating the registry as an individual program, standardization is of small consequence; but when the hospital becomes one of many participating in a central tumor registry, standardization becomes necessary to insure that all participants use the same terms to define or describe the same material.

Some persons may ask why a central tumor registry is necessary, particularly if all hospitals are maintaining a complete tumor registry? The answer is that relatively few hospitals record more than five hundred cases of cancer a year; most of them have about two hundred cases a year. These cases include all sites, including the skin. In some institutions malignant lesions of certain sites are seen rarely. It becomes necessary, then, that all such experiences be pooled in order that a better knowledge of these "rare" lesions may be gained and better diagnostic and therapeutic techniques developed. A central tumor registry would also provide means for evaluating the efficiency of therapeutic techniques by the statistical analysis of the effects upon the well-being of the patient and the length of survival, using the accepted techniques for a base.

As Dr. Harvey Cushing once said: "Records based on observation have an enduring value that transcends all our social philosophies; and the doer always does over again—always a little better, we would like to believe—what someone has done before and someone before him."

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Important!

SCIENTIFIC MOTION PICTURES

Attention—All Members of the California Medical Association

AT THE 1958 annual meeting of the California Medical Association, to be held at the Ambassador Hotel, Los Angeles, April 27 through April 30, approximately 100 motion pictures on surgery and medicine will be shown on the program of the Motion Picture Division.

The educational and scientific value of motion pictures has been proven by the large attendance at the Motion Picture Section during our previous meetings.

If you would like to present a scientific motion picture film on this program, you must submit your application to the committee for approval not later than February 15, 1958.

Address all communications to: Arthur E. Smith, M.D., D.D.S., chairman, Motion Picture Division, California Medical Association, 1930 Wilshire Boulevard, Suite 511, Los Angeles 57, California.